Part 3

EDUCATION AND RESEARCH

20. Toward Sophisticated Specialism

The time has come for American specialties in medical and surgical science to build with American scientific material and labor. "Made in America" must be the slogan in the training of our specialists of the future.

MAX A. GOLDSTEIN
Laryngoscope, 1921

To be just another *medical society is not a part of the Academy's philosophy. History reveals that medical societies whose objectives concern solely the reading of papers, good or bad, soon "lose their place in the sun."*

WILLIAM P. WHERRY, 1941

WHILE ADVANCES in medical knowledge encouraged specialization by permitting a high degree of differentiation of disease concepts, there were more mundane factors that made specialism practicable. An increasing density of population stretching across the country and aggregated into communities, towns, and cities, the laying of hard-surface roads, the advent of the automobile, the construction of county hospitals, all made it possible for the specialist to establish a base for practice and for sufficient clientele to reach him to make it economically feasible.

In the increasing popularity of specialty practice, the Academy specialties were popular choices. According to various directories, by 1923 there were almost 10,000 physicians purporting to be specialists in the eye, ear, nose, and throat in the United States alone.[1] In 1904, there had been 2,000.[2] This surge in the number of EENT specialists had occurred in the face of no appreciable increase in educational facilities for training in ophthalmology and otolaryngology, and in fact, of lost opportunity for training abroad occasioned by the First World War.

Only a minuscule number of these men were Academy members, and it would appear that a fair percentage of them were general practitioners who became EENT specialists by doing little more than announcing that they were. It is small wonder that Academy members became alarmed with the quality of practice in their specialties and made education of the specialist a dominant theme of the society. By establishing examining Boards, ophthalmology

and otolaryngology became the first fields of specialty medicine to make any attempt to define what minimum training and knowledge were necessary for practice of their specialties.

The twenties were a period of transition in the growth to maturity of specialism in medicine. First organized medicine and then academic medicine began taking a hard look at what the educational requirements for specialty practice should be and where and how the necessary training could be provided.

The strategy and apparatus for training specialists could not be conjured up overnight. American medicine was just getting on its feet in terms of solid undergraduate medical education and was unprepared for the new burden of specialty education. The formal medical education system, with a few notable exceptions, ended abruptly with the conferring of a doctor's degree.

The Academy spent most of the decade of the twenties mothering development of those programs already initiated, as well as revising its operating structure. The examining Boards for ophthalmology and otolaryngology were helping to create a demand for graduate training, and the requirement of Board certification for membership in the major ophthalmic and otolaryngologic societies was a red flag to those entering the specialties that they had better obtain proper training if they wished recognition as specialists.

Throughout medicine, the beginnings of criteria for acceptable specialty training began to rein in the hitherto open field of specialty practice. There was a perceptible attitude change toward specialism that filtered down to would-be specialists who accurately perceived that the commandments for specialists were getting tougher. The percentage of medical graduates deciding to specialize actually declined during the 1920s, although it rose steadily thereafter.

By 1930, 30% of medical graduates were going into special practice.* Of those who were specializing, 13% were specializing in eye, ear, nose, and throat.[3] The number of those choosing EENT was down from 18% in 1920 and a staggering 22% in 1915,† a decrease due in no small part to the new standards and quality being demanded in the field.[4]

In the long run, however, the development of standards meant nothing if men of earnest desire to meet those standards had no means of doing so, and in providing means, there was still a long way to go.

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*The 30% of the class of 1930 who specialized is the rock bottom percentage recorded for a 30-year period, 1915-1945. The number of medical graduates choosing to specialize had dropped from 41% in 1915 and would shoot up to 55% in 1935 and to 74% in 1945.[4]

†The classification EENT included those limiting their practice to either ophthalmology or otolaryngology as well as combined specialists. No breakdown into the three categories was made.